STATEMEN	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI			MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	L DITT	DDIC	00	COMPL	ETED
		155039	A. BUII			06/22/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	8					
MILLEDIA	C MEDDY MANOR			1	AIR PIKE IN46970		
WIILLER	S MERRY MANOR			PERU,	11146970		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was for	r the Investigation of	F0	000	Please accept this as our cre	edible	
	Complaint #IN00091997.				allegation of compliance.We		
	F				respectfully request consider		
	Complaint #IN00091997 Substantiated. Federal/state deficiencies related to the allegation are cited at F323 and F514.				for paper compliance related		
					the following plan of correction	ווע.	
	Survey dates: June 20-22, 2011						
	Facility number: 000014						
	Provider number: 155039						
	Aim number: 10	00288670					
	Survey team:						
	Honey Kuhn, RN	1					
	Census bed type:						
	SNF: 17	•					
	SNF/NF: 53						
	Total: 70						
	Medicare: 18						
	Medicaid; 39						
	Private: 13						
	Total: 70						
	101						
	C1						
	Sample: 3						
	These deficiencie	es reflect state findings					
	cited in accordan	nce with 410 IAC 16.2.					
	 Ouality review co	ompleted 6/24/11					
	Zuminy ioviow of	0/12 I/ 11					
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIC	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KUGT11

Facility ID:

000014

If continuation sheet

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		
		155039	B. WIN			06/22/2	1011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
MILLEDIS	S MERRY MANOR			1	AIR PIKE IN46970		
				PERU,	11146970		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG				IAU	j series.		DATE
	Cathy Emswiller	KIN					
F0323 SS=D	environment remain hazards as is poss receives adequate devices to prevent Based on record	nsure that the resident ins as free of accident sible; and each resident supervision and assistance accidents. reviews and interviews, to ensure the safety of 1	F0	323	It is the policy of Miller's Men manor - Peru to ensure that	the	07/08/2011
		ho incurred a fall for 1 of		residents environment remains as free of accident hazards as is			
	3 residents review	wed for falls in a sample		possible and that each resident			
	of 3. (Resident "O	_			receives adequate superviso		
	Finding includes:	sident "C" was reviewed			and assistance devices to pr accidents.Resident "C" was i low bed with a concave matt and floor mat to prevent injur A bed alarm was placed follo	in a ress ries.	
): 45 a.m. Resident "C"			his fall. He was checked eve		
					two hours per policy. Reside	ent	
		he facility, on 06/10/11 diagnoses including,			"C" expired on 6/15/11 with r		
	•	, esophageal cancer with			further falls.All new admissio who are identified as "at risk		
		pertension. Review of			falls" have the potential to be		
	_	-			affected by this deficient prac		
		indicated hospice			and will be identified through		
		n arranged prior to			facility review and audit and pre-admission assessment.li		
	_	n ACF (Acute Care			order to prevent this deficien		
). Review of the record			practice from recurring - all n		
	indicated the resi	· · · · · · · · · · · · · · · · · · ·			admissions who have been		
	*	ad incurred falls both			deemed a fall risk during the		
	-	e a patient in the ACF.			pre-admission assessment w have a "Fall Assessment" (E		
	_	on information indicated			#1) completed "upon admiss		
		received the terminal			so that fall		
	_	an 2 weeks prior, and,			"Interventions/Protocol" can		
		ve consultation, physician			implemented timely.All nursing	ng	
	·	fort measures only and			staff were inserviced at a mandatory meeting on 6/30/	11	
	Hospice services	which addressed the			manuatory meeting on 6/30/	11	

000014

terminal diagnosis, the family remained unaccepting of the diagnosis and were "praying for a miracle." The resident's medications included, but were not limited to: "Dilaudid 1.5 mg (milligrams) IV TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (Exhibit #2) on the importance of accurately and completely documenting sufficient information on each resident on a timely basis and the Fall Management program. The inservice included a review of the	STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155039	ND PLAN OF CORRECTION ID	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE S COMPL 06/22/2	ETED
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) terminal diagnosis, the family remained unaccepting of the diagnosis and were "praying for a miracle." The resident's medications included, but were not limited to: "Dilaudid 1.5 mg (milligrams) IV PREFIX TAG PREFIX (EACH DEFICIENCY) PREFIX TAG PREFIX (EACH OERECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE COMPLETION COMPLETION DATE (Exhibit #2) on the importance of accurately and completely documenting sufficient information on each resident on a timely basis and the Fall Management program. The inservice included a review of the				317 BLA	AIR PIKE	•	
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(intravenous) q (every) 4 hours PRN (as needed) for pain." "Roxinal 3 mg PO (Per Os: by mouth)/SL (Sublingual: under the tongue) q 1* (hour) for pain." "Lorazapam 0.25 mg PO q 6* PRN anxiety." "Lorazapam 0.5 mg PO q 6* PRN anxiety." "Haloperidol 5 mg IM (intramuscularly: shot) or IV q 4* as needed for agitation." The "Admission Information" form, dated 06/10/2011 at 19:15 (7:15 p.m.) (arrival time) was reviewed. Interview with the ADNS (Assistant Director Nursing Services), on 06/20/11 at 1:00 p.m., indicated the form should have indicated arrival time as 21:15 (9:15 p.m.). The ADNS provided a 24-hour report form that indicated the resident arrived at 9:15 p.m. The admission forms indicated the following resident information: "Speech/Communication:2. Unclear speech (slurred, numbled words" "Mental Status Assessment: Alert and Oriented to: 1. Self 2. Situation 3. Place 4. Time8. Lethargic/Drowsy" following policies and procedures - Exhibit #3 2. New Admission and Return to Facility Procedure - Exhibit #3 2. New Admission and Return to Facility Procedure - Exhibit #4 3. Fall Managment - Exhibit #4 4. Incident and Accident Report Procedure - Exhibit #4 5. Intervention/Protocol List - Exhibit #7 6. Post Fall Investigation - Exhibit #7 6. Post Fall Investigation - Exhibit #7 7. Narrative charting a minimum of two (2) times per shift for 3 days on all new admissions and more frequently if condition or situation variation or studion or situation warrants - Exhibit #6 7. Narrative charting a minimum of two (2) times per shift for 3 days on all new admissions and more frequently if condition or situation warrants - Exhibit #6 7. Narrative charting a minimum of two (2) times per shift for 3 days on all new admissions and more frequently if condition or situation warrants - Exhibit #8 7. Narrative charting a minimum of two (2) times per shift for 3 days on all new admissions and more frequently if condition or situation warrants - Exhibit #8 Procedure sor accurate, complete and timely documention. To e	terminal di unacceptin "praying fo The resider were not li "Dilaudid (intravenor needed) for "Roxinal 3 (Sublingua for pain." "Lorazapar anxiety." "Lorazapar anxiety." "Haloperid shot) or IV The "Admi 06/10/2011 time) was ADNS (As Services), o indicated th arrival time ADNS pro that indicat p.m. The a following r "Speech/Co speech (slu "Mental St Oriented to	nosis, the family remained of the diagnosis and were miracle." Is medications included, but ted to: Img (milligrams) IV Inq (every) 4 hours PRN (as ain." Ing PO (Per Os: by mouth)/SL ander the tongue) q 1* (hour) Index the tongue) q 1* (hour) Index the tongue) q 6* PRN Index the tongue) q 6* PRN Index the tongue of the ton	terminal diagnosis, unaccepting of the "praying for a mira The resident's med were not limited to "Dilaudid 1.5 mg ((intravenous) q (ev needed) for pain." "Roxinal 3 mg PO (Sublingual: under for pain." "Lorazapam 0.25 manxiety." "Lorazapam 0.5 mg anxiety." "Haloperidol 5 mg shot) or IV q 4* as The "Admission In 06/10/2011 at 19:1 time) was reviewe ADNS (Assistant I Services), on 06/20 indicated the form arrival time as 21:1 ADNS provided a 2 that indicated the rep.m. The admission following resident "Speech/Communi speech (slurred, mu "Mental Status Ass Oriented to: 1. Self	IAG	(Exhibit #2) on the importa accurately and completely documenting sufficient information on each reside timely basis and the Fall Management program. The inservice included a review following policies and procedures: 1. Charting Procedure - Exhibit #3 2. Admission and Return to Procedure - Exhibit #4 3. Managment - Exhibit #5 4. Incident and Accident Rep Procedure - Exhibit #6 5. Intervention/Protocol List-#7 6. Post Fall Investigati Exhibit #8 7. Narrative che minimum of two (2) times shift for 3 days on all new admissions and more frequif condition or situation was Exhibit #9Review of these policies and procedures with established procedures with ensuring that staff are for established procedures for accurate, complete and tire documention. To ensure compliance with the system policies - the DON and/or designee will the complete Tool - "Falls Risk Manager Review" (Exhibit #10) and "Admission Audit" (Exhibit all new admissions identification fall risk daily times 2 week weekly times 4 weeks and monthly there after per procedure of the procedur	ent on a ne v of the New Facility Fall ort Exhibit on - arting a per uently arrants - ill assist bllowing nely m and e the QA ment #11) on ed as a s, then btocol. ented y tee	DATE

IDENTIFICATION NUMBER: 185039 S NOTES (TY. STATE, APP CODE 3 TREFT ADDRESS, CITY, STATE, APP COD		TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	ONSTRUCTION	(X3) DATE	
MILLER'S MERRY MANOR (X4) ID PREFIX (RACH DEFICIENCY MIST BE PERCEDED BY FULL TAG (Pain Assessment: 1. Is resident experiencing pain Yes 2. Location: sub sternal and middle of back 3. Pain scale: 3-5 (hurts a little more (electronic signature of LPN #2" The form did not address falls. Interview with the ADNS indicated a separate "Fall Assessment" is to be done within 8 hours of admission. The ADNS indicated standard fall prevention measures were put into effect at admission, which included a low bed, a concave mattress and a fall mat (a mat placed next to mattress to prevent injury). The ADNS indicated bed alarms are not placed prior to a fall. Review of Progress Notes (Nurses notes) following admission indicated the first 3 entries: "06/11/2011 07:05 call placed to hospice nurse (name) and notified of res fall with abrasions and of res being non verbal at this dime and during neurochecks noted right side hand grip weaker than left. Stated she would be in around 9 am to see res. (day nurse electronic signature: 1.PN #3)" "06/11/2011 07:05 Late Entry: (name) (hospice nurse) also stated just to wait to notify res wife of fall until she gets here	AND PLAN	OF CORRECTION				00	1	
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entries: "06/11/2011 07:05 call placed to hospice nurse (name) and notified of res fall with abrasions and of res being non verbal at this dime and during neurochecks noted right side hand grip weaker than left. Stated she would be in around 9 am to see res. (day nurse electronic signature: LPN #3)" "06/11/2011 07:05 Late Entry: (name) (hospice nurse) also stated just to wait to notify res wife of fall until she gets here								
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abrasions and of res being non verbal at this dime and during neurochecks noted right side hand grip weaker than left. Stated she would be in around 9 am to see res. (day nurse electronic signature: LPN #3)" "06/11/2011 07:05 Late Entry: (name) (hospice nurse) also stated just to wait to notify res wife of fall until she gets here			•					
this dime and during neurochecks noted right side hand grip weaker than left. Stated she would be in around 9 am to see res. (day nurse electronic signature: LPN #3)" "06/11/2011 07:05 Late Entry: (name) (hospice nurse) also stated just to wait to notify res wife of fall until she gets here		· · ·						
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Stated she would be in around 9 am to see res. (day nurse electronic signature: LPN #3)" "06/11/2011 07:05 Late Entry: (name) (hospice nurse) also stated just to wait to notify res wife of fall until she gets here			•					
res. (day nurse electronic signature: LPN #3)" "06/11/2011 07:05 Late Entry: (name) (hospice nurse) also stated just to wait to notify res wife of fall until she gets here		~ ~	•					
#3)" "06/11/2011 07:05 Late Entry: (name) (hospice nurse) also stated just to wait to notify res wife of fall until she gets here								
"06/11/2011 07:05 Late Entry: (name) (hospice nurse) also stated just to wait to notify res wife of fall until she gets here		· -	Č					
(hospice nurse) also stated just to wait to notify res wife of fall until she gets here		ĺ						
(hospice nurse) also stated just to wait to notify res wife of fall until she gets here		"06/11/2011 07:0	05 Late Entry: (name)					
notify res wife of fall until she gets here			• , ,					
			-					
		1 *	•					
rest and will be in to facility this am.		_	_					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	ONSTRUCTION	(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155039	A. BUI	LDING	00	06/22/2	
		155059	B. WIN			00/22/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MILLER'S	S MERRY MANOR			1	IN46970		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	(electronic signat	ture of day nurse: LPN					
	#3)"						
	"06/11/2011 08:15 Family here and						
		lls X 2 with abrasions					
	_	ip on right side. Also					
	l	given PRN pain med per					
		ng out of be onto floor.					
	1	raught and stated this is a					
	1 ~ ~	yesterday. Stated					
	yesterday res was						
	bed unassisted and was talking without difficulty. Writer explained that res had						
	I -	_					
		ince writer got here this					
	_	that it took 3 staff and a st res back to his bed after					
	l *	red family that we would					
		ortable as possible and					
	1 ^	nad notified Hospice and					
		ere around 9 am to assess					
	1	quietly in bed with family					
	and friends at bed						
	(electronic signat	ture of day nurse: LPN					
	#3)"						
	The ADNS, during						
		ent fall would not be					
		rogress Notes but on an					
		ial Assessment". Review					
		Initial Assessment" forms					
	· · · · · · · · · · · · · · · · · · ·	ere reviewed with the					
		nt "C" and indicated:					
	Occurrence #1:	2011 07 20					
	"1. Time: 06/11/2	2011 06:30					

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Event ID:

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If continuation sheet

Page 5 of 18

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR STREET ADDRESS, CITY, STATE, ZIP CODE 317 BLAIR PIKE PERU, IN46970	
CAN ID CAN DATA TO A DEPOSIT OF D	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	(X5) COMPLETION DATE
2. Location: res (resident's) room 3. Found res lying on floor in front of bathroom door" Vital signs were recorded and neuro checks (checking of grips, pupils, orientation) were started7. Complete head to toe assessment,f. abrasionj. Describe all injuries noted above: 2 cm (centimeter) X (by) 1 cm abrasion to right inner foot. 3 abrasions to left knee measuring as follows: 3.3 cm X 1.7 cm, 1 cm X 1 cm, and 3.5 cm X 1.8 cm; also noted 5 cm X 3 cm reddened area to right check. The physician was notified. (day nurse electronic signature: LPN #3)" Occurrence #2: "1. Time: 08:00 2. Location: res room 3. res bed alarm going off and res found sitting on mat on floor beside bed. res appearing agitated and restless. PRN pain med given for s/s (sign/symptoms) pain" Vital signs (V/S) and neuro checks continued. No new injuries noted. (day nurse electronic signature: LPN #3)" Review of a "Post Fall Investigation" by the facility indicated: The fall occurred on 06/11/11 at 6:30 a.m. The resident was noted to have fallen within 30 days. Resident "C" appeared to be attempting to ambulate to the bathroom and "was in bed	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155039	A. BUILDIN		00	(X3) DATE S COMPL 06/22/2	ETED
	PROVIDER OR SUPPLIER		3	17 BLA	DDRESS, CITY, STATE, ZIP CODE IR PIKE N46970	00/22/2	···
							775
(X4) ID		TATEMENT OF DEFICIENCIES CV MUST BE BEDCEDED BY FULL	II DD I		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`			AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE
PREFIX TAG	and got up and traces and got up and traces at the time of the present at the time was signed as revolution of the present at the time was signed as revolution of the present at the time was signed as revolution of the present at the time was signed as revolution of the present at the time was completed in the signed of the present at the fall. The members fill out investigation for queried if Administration for queried if Administration of the present was last. The ADNS indiction indicates for furth done. Review of the resident was last. The ADNS indiction of the present indicated the Host facility and did at on 06/10/11 at 90 assessment indiction, and was assessed as last a fall assessment was a "High Risk information indiction."	ms. The ADNS was instrative staff further members for when the checked, toileted, etc. ated the protocol did not er investigation to be ecord for Resident "C" spice nurse arrived at the nadmission assessment 30 p.m. The hospice ated the resident required rson for transfer, toileting. Resident "C" being in frequent pain and indicated the resident		OFIX AG	CROSS-REFERENCED TO THE APPROPRIA	TE .	DATE

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155039	A. BUILDING	00	06/22/2011
		133039	B. WING		00/22/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE AIR PIKE	
MILLER'S	S MERRY MANOR			IN46970	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I ID	Ī	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	exiting the facilit	y.	ĺ	•	
	Interview with th	e ADNS, on 06/21/11 at			
	10:00 a.m. indica	ted the resident was			
	_	and repositioned every 2			
		admission. The ADNS			
		N medication sheet			
	indicated how Re				
	1 0	edications for pain and/or			
	agitation/anxiety	•			
	_	sion until the 1st Progress			
	Note entry at 7:05 a.m. on 06/11/11 by				
	LPN #3.				
	I DN #3 was inter	rviewed on 06/21/11 at			
		#3 indicated she was			
		rival to her unit Resident			
	•	it of bed and incurred a			
		g night shift. LPN #3			
	_	s summoned to assess			
		then notified the			
		phone. The Hospice			
		r not to notify the family			
		ated arrival the morning			
	•	#3 indicated Resident			
	"C" had a rapid d	lecline after admission.			
	LPN #2, the nurs	e who completed the			
	admission assess	ment, was unavailable			
	for interview.				
	The PRN medica				
	admission throug	:			
		21/11 at 11:00 a.m The			
	documentation in	ndicated Resident "C"			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155039	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COME 06/22/	LETED
	PROVIDER OR SUPPLIER	2	317 BL/	ADDRESS, CITY, STATE, ZIP (AIR PIKE IN46970	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	nurse. The resid Hospice nurse to 1:30 a.m. The not 8:00 a.m. when I medicated for particle a.m. by LPN #2. contain informat "C" was observe 6:30 a.m., prior to fall. Review of a facilititled, "Intervent Risk-09/01/2004"3. Staff Routi a. Anticipate car residents" Review of a facilititled, "Charting indicated: 1. Purpose: A. To accurately organized manner information relationed: 1. medical record	ine: re needs for confused lity Policy and Procedure, Procedure-11/02/20010" document in an er all pertinent ted to the resident in the				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/14/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155039	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/22/2011
	PROVIDER OR SUPPLIER		317 BL	ADDRESS, CITY, STATE, ZIP CODE AIR PIKE IN46970	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0514 SS=D	each resident in a professional stand complete; accurate accessible; and sy. The clinical record information to ider the resident's asse and services provipreadmission screes tate; and progres Based on record facility failed to policy and proceresident who fell residents reviewed documentation. Finding includes The record of Re on 06/20/11 at 10 was admitted to a at 9:15 p.m., with	review and interview, the follow the facility's dure in regards to 1 of 1 in a sample of 3 ed for falls and (Resident "C")	F0514	It is the policy of Miller's Me Manor - Peru to ensure that clinical records are complete accurately documented. Res "C" expired on 6/15/11All residents have the potential affected by this deficient pra and will be identified through review of the Daily Condition Report (Exhibit # 12) and subsequent review by the DON/designee of document of any significant changes to ensure that documentation/assessment accurate, complete and time nursing staff were inserviced.	e and sident to be actice h n cation o s are ely.All

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Event ID:

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If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		155039	B. WIN			06/22/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		317 BL/	AIR PIKE		
	S MERRY MANOR				IN46970		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	mandatory meeting on 6/30/	11	DATE
	metastasis and hypertension. Review of				(Exhibits # 2-9).Review of th		
		s indicated hospice			policies and procedures will		
		n arranged prior to			in ensuring that staff are follo		
	1	an ACF (Acute Care			established procedures for		
	Facility: hospita	l). Review of the record			accurate, complete and time	ly	
	indicated the res	sident was weak,			documention.To monitor compliance - the DON/desig	nee	
	debilitated, and	had incurred falls both			will be responsible for compl		
	prior to and whi	le a patient in the ACF.			of the QA Tool "On-going Me		
					Records Audit" (Exhibit #13)		
	The "Admission	Information" form, dated			times 2 weeks, then weekly		
	06/10/2011 at 19:15 (7:15 p.m.) (arrival time) was reviewed. Interview with the				4 weeks and monthly therea	fter	
					per protocol. Any identified trends will be reviewed by th	e	
	· ·	nt Director Nursing			Quality Assurance committee		
	`	/20/11 at 1:00 p.m.,			during monthly meetings.Ch		
		m should have indicated			nurses responsibleDON and		
		1:15 (9:15 p.m.). The			Designee will monitor compl	iance	
		a 24-hour report form					
	1 -	e resident arrived at 9:15					
	_	sion forms indicated the					
	following reside						
	_	unication:2. Unclear					
		mumbled words"					
		Assessment: Alert and					
		Self 2. Situation 3. Place					
		hargic/Drowsy"					
		nt: 1. Is resident					
		inYes 2. Location: sub					
	sternal and midd	lle of back3. Pain scale:					
	3-5 (hurts a little	e more (electronic					
	signature of LP1	N #2"					
	The form did no	t address falls. Interview					
	with the ADNS	indicated a separate "Fall					
	1	to be done within 8 hours					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M A. BUI		NSTRUCTION 00	(X3) DATE S COMPL		
		155039	B. WIN			06/22/2	011
	PROVIDER OR SUPPLIER			317 BL	ADDRESS, CITY, STATE, ZIP CODE AIR PIKE IN46970		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	of admission. The standard fall presuput into effect at included a low be and a fall mat (a mattress to prevenindicated bed alarto a fall. Review of Prografollowing admissions: "06/11/2011 07: nurse (name) and abrasions and of this dime and duright side hand general Stated she would rese (day nurse effect): "06/11/2011 07:00 (hospice nurse) and notify res wife of d/t she was up al rest and will be in (electronic signarial." "06/11/2011 08:	ne ADNS indicated vention measures were admission, which ed, a concave mattress mat placed next to ent injury). The ADNS rms are not placed prior ess Notes (Nurses notes) sion indicated the first 3 05 call placed to hospice d notified of res fall with res being non verbal at ring neurochecks noted rip weaker than left. I be in around 9 am to see dectronic signature: LPN 05 Late Entry: (name) also stated just to wait to fall until she gets here I night and could use her in to facility this am. ture of day nurse: LPN 15 Family here and alls X 2 with abrasions		TAG	DEFICIENCY)		DATE
	notified that res	rip on right side. Also given PRN pain med per ng out of be onto floor.					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			JRVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00 COMPL			COMPLE	TED
155039		B. WING 06/22/2011				11	
NAME OF I	DROVADED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF PROVIDER OR SUPPLIER				317 BL/	AIR PIKE		
MILLER'S MERRY MANOR					IN46970		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	TAG	DEFICIENCY)		DATE
	Family very distraught and stated this is a						
	1	yesterday. Stated					
	1 *	s able to sit up on side of					
		nd was talking without					
		r explained that res had					
		ince writer got here this					
	1 ^	d that it took 3 staff and a					
	I -	et res back to his bed after					
	fall. Writer assur	red family that we would					
	keep res as comf	ortable as possible and					
	told her that we h	nad notified Hospice and					
	they would be he	ere around 9 am to assess					
	res. Res resting	quietly in bed with family					
	and friends at be	dside at this time.					
	(electronic signat	ture of day nurse: LPN					
	#3)"	,					
	,						
	The ADNS, durin	ng the interview,					
	•	ent fall would not be					
	recorded in the P	rogress Notes but on an					
		ial Assessment". Review					
		Initial Assessment" forms					
		ere reviewed with the					
		nt "C" and indicated:					
	Occurrence #1:	nt C una marcatoa.					
	"1. Time: 06/11/2	2011-06:30					
	2. Location: res (resident's) room 3. Found res lying on floor in front of bathroom door" Vital signs were recorded						
		s (checking of grips,					
		n) were started7.					
	1 -	o toe assessment,f.					
	· ·	cribe all injuries noted					
	above:						

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I		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155039		A. BUI	LDING	00	COMPL 06/22/2		
		155059	B. WIN			00/22/2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
MILLEDIC MEDDY MANOD				1	AIR PIKE IN46970		
	MILLER'S MERRY MANOR			<u> </u>	11140970		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX TAG				PREFIX TAG			COMPLETION DATE
IAG			-	IAG	,		DAIL
	`	Y) X (by) 1 cm abrasion to					
	right inner foot.	Q. 1					
		ft knee measuring as					
		X 1.7 cm, 1 cm X 1 cm,					
		3 cm; also noted 5 cm X					
		rea to right cheek. (day					
	nurse electronic	signature: LPN #3)"					
	Occurrence #2:						
	"1. Time: 08:00						
	2. Location: res room 3. res bed alarm						
	1 " "	found sitting on mat on					
		res appearing agitated					
	and restless. PRN pain med given for s/s (sign/symptoms) pain" Vital signs (V/S) and neuro checks continued. No new						
	`	day nurse electronic					
	signature: LPN #3)"						
		- T 11 T					
		st Fall Investigation" by					
	1	ated: The fall occurred					
		30 a.m. The resident was					
		len within 30 days.					
	1 ^ ^	peared to be attempting to					
		pathroom and "was in bed					
		ried to get to bathroom"					
		s noted to be incontinent					
		fall. No staff were					
	1 *	ne of the fall. The form					
	was signed as rev	viewed by the ADNS on					
	06/20/11. The A	DNS was queried on					
	06/22/11 in regar	rds to the "Post Fall					
	Investigation". 7	The ADNS indicated the					
	form was comple	eted by another staff					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			ATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPL	COMPLETED	
		155039	B. WING			06/22/2011	
		<u> </u>	P. 1121		ADDRESS, CITY, STATE, ZIP CODE	I	
NAME OF PROVIDER OR SUPPLIER				1	AIR PIKE		
MILLER'S MERRY MANOR				1	IN46970		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	member. The in	vestigation indicated a					
	bed alarm was ir	place but it was a					
	recording error a	and the alarm was placed					
	after the fall. Th	ne ADNS indicated staff					
	members fill out	the Post Fall					
		ms. The ADNS was					
	_	nistrative staff further					
	1 *	f members for when the					
		checked, toileted, call					
	1 -	ADNS indicated the					
	protocol did not indicate further investigation to be done to address falls.						
	Davious of the m	ecord for Resident "C"					
		spice nurse arrived at the					
	1 *	n admission assessment					
		:30 p.m. The hospice					
	assessment indic	eated the resident required					
	the assist of 1 pe	erson for transfer,					
	ambulation, and	toileting. Resident "C"					
	was assessed as	being in frequent pain and					
	a fall assessment	indicated the resident					
	was a "High Ris	k" for falls. The					
	_	cated the Hospice nurse					
		n LPN #2 prior to exiting					
	the facility.	1					
	Interview with the	ne ADNS, on 06/21/11 at					
	10:00 a.m. indicated the resident was checked by staff and repositioned every 2 hours following admission. The ADNS						
		N medication sheet					
	indicated the FK						
	responding to me	edications for pain and/or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155039	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/22/2	ETED
NAME OF BROWN	NED OD GLIDDI IED		D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF PROVIDER OR SUPPLIER				1	AIR PIKE		
MILLER'S MERRY MANOR				PERU,	IN46970		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
I				PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	THE APPROPRIATE	
-	agitation/anxiety during the time		+	IAG			DATE
1 -	-	sion until the 1st Progress					
	_	5 a.m. on 06/11/11 by					
I	N #3.	, and the second					
LPN	N #3 was inter	rviewed on 06/21/11 at					
		#3 indicated she was					
	•	rival to her unit Resident					
I		at of bed and also had					
		rlier during night shift.					
		d she was summoned to					
I		C" and then notified the					
	-	r phone. The Hospice r not to notify the family					
		ated arrival the morning					
I	•	#3 indicated Resident					
		lecline after admission.					
I	•	e who completed the					
		sment, was unavailable					
for i	interview.						
I		tion sheets, from					
I	•	th 06/15/11, were					
		21/11 at 11:00 a.m The					
		ndicated Resident "C"					
		or pain and nausea on					
I		a.m. by the Hospice					
		ent was noted by the					
I	Hospice nurse to be resting/sleeping at 1:30 a.m. The next entry was 06/11/11 at						
		Resident "C" was					
		in and the resident was					
I	-	oing eyes shut" at 8:05					
	-	The record did not					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155039	B. WIN			06/22/2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
AUL EDIO MEDDIVAMANOD					AIR PIKE		
	S MERRY MANOR				IN46970		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORP PREFIX (EACH CORRECTIVE ACTION SE			(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG	+	ion to indicate Resident	+	IAG	,		DATE
		d between 1:30 a.m. and					
		to or following the 1st					
	fall.	to or ronowing the 1st					
	lan.						
	There was docur	mentation by the night					
		#2, in regards to the fall					
	1	30 a.m. on either					
		or the Occurrence form to					
	_						
	indicate circumstances prior to or following the fall.						
	Review of a faci	lity Policy and Procedure,					
		Procedure-11/02/20010"					
	indicated:						
	1. Purpose:						
	_	document in an					
	organized manne						
	~	ted to the resident in the					
	medical record						
	2. Pertinent Cha	arting:					
	1	on will be completed for					
	1	es either in progress notes					
	or in the assessm	nent module of the EMR					
	(Electronic Med	ical Record). Includes,					
	,	l to the following:					
	I. Any incident	or accident occurrence or					
	1 -	rence will be documented					
	on the EMR form						
		il" or Nursing occurrence					
	follow-up.						
	II. Any physical	or emotional symptom or					
		e documented in the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155039	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 06/22/	LETED		
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 317 BLAIR PIKE PERU, IN46970					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
TAG	progress notes. A will be documen notes"	Any condition change ted in the progress relates to Complaint	TAG	DEFICIENCY)		DATE		